

**§ 54.9815-2712T Rules regarding rescissions (temporary).**

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group health insurance coverage, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if—

(i) The cancellation or discontinuance of coverage has only a prospective effect; or

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(3) The rules of this paragraph (a) are illustrated by the following examples:

*Example 1.* (i) *Facts.* Individual A seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires A to complete a questionnaire regarding A's prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: "Is there anything else relevant to your health that we should know?" A inadvertently fails to list that A visited a psychologist on two occasions, six years previously. A is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about A's visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1*, the plan cannot rescind A's coverage because A's failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

*Example 2.* (i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual B has coverage under the plan as a full-time employee. The employer reassigns B to a part-time position. Under the terms of the plan, B is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from B and paying claims submitted by B. After a routine audit, the plan discovers that B no longer works at least 30 hours per week. The plan rescinds B's coverage effective as of the date that B changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2*, the plan cannot rescind B's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for B prospectively, subject to other applicable Federal and State laws.

(b) *Compliance with other requirements.* Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Effective/applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. See § 54.9815-1251T for determining the application of this section to grandfathered health plans (providing that the rules regarding rescissions and advance notice apply to all grandfathered health plans).

(d) *Expiration date.* This section expires on June 21, 2013.

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**§ 54.9815-2713T Coverage of preventive health services (temporary).**

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) *Office visits*—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is

tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

*Example 1.* (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1*, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

*Example 2.* (i) *Facts.* Same facts as *Example 1*. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2*, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

*Example 3.* (i) *Facts.* An individual covered by a group health plan visits an in-network